Meeting Notes
Quality Metrics Subcommittee Meeting
November 9, 2011

Members present: **Paula Block**, CHC-Montana Primary Care Association; **Dr. Doug Carr**, Billings Clinic; **Dr. Janice Gomersall**, Montana Academy of Family Physicians; **Dr. Jonathan Griffin**, St. Peter's Medical Group; **Caroline Hoffman**, Pfizer; **Carol Kelley**, Bozeman Deaconess Internal Medicine Associates; **Janice Mackenson,** Mountain Pacific Quality Health; **Dr. Fred Olson**, BCBS MT; **Dr. Bob Shepard**, New West Health Services; **Dr. Rob Stenger**, Grant Creek Family Practice, St. Patrick's Hospital; **Cindy Stergar**, Butte Silver Bow Primary Health Care Clinic

Interested Parties present: **Dr. Jay Larson**, Independent Provider**;** Nancy Wikle, DPHHS Medicaid, Care Management Supervisor; **Kristin Juliar**, Montana Office of Rural Health; **Dr. Paul Cook**, Rocky Mountain Health Network; Dwight Easterman, Mountain Pacific Quality Health Foundation

CSI Staff present: Christine Kaufmann, Amanda Roccabruna Eby

The meeting was called to order by Chair, Dr. Bob Shepard at 1:05 PM.

1. Notes from the previous meeting on October 26, 2011 were reviewed and the subcommittee agreed they accurately represented the meeting and could be submitted to the advisory council for adoption.

2. Discussion of updated Quality Metrics Spreadsheet
   The subcommittee discussed the metric for a patient's preferred method of communication in regard to hearing, vision, or language issues. Members agreed that newer EHR systems should not have trouble collecting all this information, even as specific as impediments of the right or left ear or eye. If some EHR's couldn't capture the information then there could be exceptions made. Members agreed that a distinction needed to be made between preferred method of communication and communication barriers. They agreed to add "literacy" to the list of communication barriers.

   Members discussed and agreed to add a question about when a patient quit using tobacco to the tobacco use list.

   The daily aspirin use suggestion was changed because there is no way to track purchase of over-the-counter medication. Instead the measure will track whether the patient has been informed of the need for daily aspirin and/or reports taking a daily aspirin.

   Dr. Shepard commented that some of the information needed to be collected for the chronic heart failure measures would require specific test results. This may be difficult and more work would be need for that measure.

   Under the immunizations list, the HPV measure was changed to remove reference to females, as it is effective for both sexes.

   Under appointment availability, the first two measures will be dealt with later, in phase II, but the last three can be determined by claims data and should be included.

3. Discussion of NCQA CAHPS survey

   Members discussed the key highlights from a webinar they viewed earlier that week about a patient satisfaction survey. NCQA recommended against having patients fill out the survey in the waiting room because it created a significant bias compared to those who returned an email or mail-in survey. Members questioned the response rate expected with those techniques, then agreed that we not put parameters on where or how the survey is conducted. Some members commented that practices should be encouraged to conduct the survey electronically and they would need a web-based portal to be able to communicate with patients through secure messaging. Members commented that more work would need to be done on tailoring the survey given our small sample size. Dr. Shepard will send out to the list serve a copy of the survey and some NCQA guidelines that accompany it such as frequency and level of comprehensiveness.

4. Discussion of patient preferred communication metric

   The subcommittee accepted two lists as detailed above.

5. Remaining Steps

   a. Mental Health
      Although mental health metrics are difficult, members discussed the possibility of at least attempting to measure depression. They mentioned the importance of considering mental health similarly to physical health. Depression screening is done at the physical exam, not at a separate specific mental health visit. It could be included in phase 1 just as tobacco use is. It is at least as prevalent as tobacco use and is also linked to heart disease and diabetes. Members suggested using the NCQA anti-depressant monitoring criteria for the metrics in addition to the simple yes/no question on whether or not the patient was screened for depression. Providers will have to check their EMR's capability for this metric and then we will have to see how this will work in the data repository. No decision was made on specifically how to proceed.

   b. Setting Benchmarks
      Members discussed the need for doing data reporting the first year of the pilot project before setting benchmarks. Further discussion was postponed until the next meeting.

6. Next Meeting

   November 30th 1:00 PM